SF 4400-SSG # (9-99) Supersedes (12-98) issue

REIMBURSEMENT SPENDING ACCOUNT CLAIM FORM

INSTRUCTIONS

- Expenses eligible for reimbursement are: (a) medical expenses incurred for you, your spouse and your ***tax*** dependent(s), of the type that are normally deductible on a federal income tax return; and, (b) day care expenses of the type that are eligible for a tax credit on a federal income tax return. You should keep records to verify your expenses as you would for your tax return. **If you are not sure about an expense, check with a tax advisor.** Like your tax return, expenses reimbursed through these accounts are subject to review.
- For medical expenses that were submitted to an insurance company but not paid, or partially paid, by that company, attach copies of the Explanation of Benefits. Co-payment receipts can be sent directly to SilverStone Group, Inc., along with this claim form. For all other reimbursable expenses, copies of the invoices/bills **must be attached** which show: who (name and address) rendered the service, patient's name, description of the expense, date of service and amount of the charge. Complete the Health Care Expense Certification boxes below. You only need to complete the Description of Expense column if this information is not indicated on your attachment(s).
- For day care expenses, if you complete this form and your day care provider signs it, no other itemized statement is required. If you opt to send in an itemized statement instead, it must include the service date, dependent name, provider name, provider's TIN/SSN, provider's address, and the amount of the charge. If you send in an itemized statement with the above information, you only need to complete the service dates, dependent name, age and amount requested under Day Care Expense Certification.
- Make a copy for your records and submit the original of this form to: **SILVERSTONE GROUP, INC., FLEX CLAIMS DEPT., P.O. BOX 540130, OMAHA, NE 68154-0130**
- If you have any questions, please contact SilverStone Group, Inc. at **1-800-288-5501**.

COMPANY (EMPLOYER) NAME **Sandia National Laboratories**

CHOICEFLEX NUMBER **FSAM - 3K09** DAYTIME PHONE: **( )** _____

EMPLOYEE NAME _____ SOC SEC NO _____ - ___ - _____

EMPLOYEE ADDRESS _____ CITY _____ STATE _____ ZIP _____

Is this a new address? ☐Yes ☐No

HEALTH CARE EXPENSE CERTIFICATION

Service Date	Patient Name(1)	Description of Expense (e.g. office visit, eye exam, prescription)	Amount Requested

Total _____

DAY CARE EXPENSE CERTIFICATION

Service Dates From	To	Dependent Name(2)	Age	Provider Name	Provider TIN/SSN	Amount Requested

Total _____

Day Care Provider's Original Signature:_____

Day Care Provider's Address:_____

(1) Only medical expenses for you, your spouse and your *tax* dependent(s) you claim on your federal tax return are eligible for reimbursement.

(2) Only day care expenses incurred by you and your dependent(s) you claim on your federal tax return are eligible for reimbursement.

I hereby certify that my expenses submitted with this form comply with the Reimbursement Spending Account Plan for Sandia and have not been reimbursed or are not reimbursable from any other program or policy. I will not use these expenses as a deduction or tax credit on my personal income tax return. I understand that I am responsible for the tax consequences of my reimbursement request. I further understand that any day care expenses incurred while my spouse or I, if applicable, are out on a sickness absence may not be eligible for reimbursement. I have been advised to consult my tax advisor if I have any questions.

_____ _____

Employee Signature **Date**